

received no comments disagreeing with this proposal and will adopt this recommendation for 2004.

*ff. Gastrointestinal Endoscopic Stenting Procedures*

APC 0141: Upper GI Procedures

APC 0142: Small Intestine Endoscopy

APC 0143: Lower GI Endoscopy

APC 0147: Level II Sigmoidoscopy

A commenter requested that we create a new APC that will be comprised of all the gastrointestinal endoscopic stent codes. The Panel agreed with the commenter's suggestion because the

resource requirements for all gastrointestinal endoscopic stents appear to be similar. The Panel recommended that we move the following CPT codes from their 2003 APCs to newly created APC 0384 for 2004:

TABLE 4.—HCPCS CODES TO BE MOVED INTO NEW APC 0384

HCPCS	Description	2003 APC	2004 APC
43219 .....	Esophagus endoscopy .....	0141	0384
43256 .....	Upper GI endoscopy w/stent .....	0141	0384
44370 .....	Small bowel endoscopy w/stent ....	0142	0384
44379 .....	Small bowel endoscopy w/stent ....	0142	0384
44383 .....	Small bowel endoscopy .....	0142	0384
44397 .....	Colonoscopy w/stent .....	0143	0384
45387 .....	Colonoscopy w/stent .....	0143	0384
45327 .....	Proctosigmoidoscopy w/stent .....	0147	0384
45345 .....	Sigmoidoscopy w/stent .....	0147	0384

We proposed to accept the Panel's recommendation to move the following gastrointestinal endoscopic stent CPT codes into newly created APC 0384:

43219, 43256 (from APC 0141); 44370, 44379, 44383 (from APC 0142); 44397, 45387 (from APC 0143); 45327, 45345 (from APC 0147). We received no comments disagreeing with this proposal, and we will adopt it for 2004.

*gg. Capturing the Costs of Devices That Are Packaged Into APCs*

APC 0081: Non-Coronary Angioplasty or Atherectomy

APC 0083: Coronary Angioplasty and Percutaneous Valvuloplasty

APC 0104: Transcatheter Placement of Intracoronary Stents

APC 0222: Implantation of Neurological Device

APC 0223: Implantation of Pain Management Device

APC 0227: Implantation of Drug Infusion Device

APC 0229: Transcatheter Placement of Intravascular Shunts

Several commenters requested that the status indicators for the above APCs (all of which include high-cost devices) be changed from T (multiple-procedure discount applies) to S (multiple-procedure discount does not apply). Two presenters to the Panel stated that hospitals do not pay less for devices when they are used in the context of a multiple-procedure claim and suggested that we apply the multiple-procedure reduction to the non-device portion of the claim only. Alternatively, these presenters recommended that we apply the discount policy only when the device cost is below a predetermined proportion of the APC cost. Another presenter to the Panel requested that APCs 0222, 0223, and 0227 be exempt

from the multiple-procedure discount policy because the cost of the devices used in these procedures makes up more than 50 percent of the APC cost.

We sought the Panel's input as to whether there are situations in which we should not apply our multiple procedure discount policy. The Panel recommended no changes to the status indicators for any of the device-related APCs discussed because they were concerned that exemptions from the discount policy could result in incentives to use more devices than necessary. However, the Panel asked that we analyze our data to determine if we may be underpaying for devices when the multiple procedure discounting policy is applied and recommended that we develop some methodology to track device costs. In section II.B of this preamble, we discuss the issue of device costs and multiple procedure reductions and our progress to date in developing "combination APCs" to address the Panel's concern.

*hh. Discussion of Ways To Increase the Use of Multiple Claims To Set APC Payment Rates*

A presenter to the Panel suggested that we use dates of service on multiple procedure claims to increase the number of claims we use to set payment rates. Another presenter suggested that we could further increase the number of multiple procedure claims that could be used to set payment rates by ignoring codes with status indicator K. Other suggestions were to exclude from consideration those APCs with small dollar values and to create a new code or APC specifically for the insertion and removal of devices.

The Panel recommended that our staff explore ways to increase the number of

claims used to set payment rates, including the following methodologies: sort multiple claims by date of service; exclude codes with K status indicator from evaluation; exclude those APCs with nominal costs (the definition of "nominal" can be determined by modeling a variety of possible dollar amounts). In addition, the Panel recommended that we not create G codes as part of the effort to use multiple procedure claims for developing relative weights. If new codes are needed, the Panel suggested that our staff work with the American Medical Association's CPT Board to identify possible new codes.

*B. Other Changes Affecting the APCs*

*1. Limit on Variation of Costs of Services Classified Within an APC Group*

Section 1833(t)(2) of the Act provides that the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest cost item or service within an APC group is more than 2 times greater than the lowest cost item or service within the same group. However, the statute authorizes the Secretary to make exceptions to this limit on the variation of costs within each APC group in unusual cases such as low volume items and services. No exception may be made in the case of a drug or biological that has been designated as an orphan drug under section 526 of the Federal Food, Drug, and Cosmetic Act.

Taking into account the proposed APC changes discussed in relation to the APC Panel recommendations in section II.A.4 of this preamble and the use of 2002 claims data to calculate the